RECOMMENDATIONS FOR CONTINUED SERVICES

Name of Inpatient Facility

Identifying Information

Patient				**SSN**				**Medical Record #**			
Address				**Phone**				**Facility Code**			
Admission Date		**Sex**		**Age**		**Date of Birth**			**Race**		
Name of Parent/ Guardian/Caretaker						**Home Phone**			**Work Phone**		
Custody		**Non-Custody**		**County of Charges**				**Hearing Date**			

Insurance Information

Enrolled in TennCare	**Yes**		**End Date**		**No**		**Pending**		**Commercial Insurance**	**Yes**		**No**	
Name of Insurance/ BHO Contact Person & Phone													
Name of DCS/CSA TennCare Representative & Phone													

Legal/Charges

Charges and Date of Charges											
Sex offense charge	**Y**		**N**		**If Yes, List sex offense charge**						
Psychosexual Requested	**Y**		**N**		**Psychosexual Completed**	**Yes**		**No**		**Pending**	

RECOMMENDATIONS

RTF	**Y**		**N**		**If Yes, Indicate Type**	**MR**		**A&D**		**Sex Offender**		**Other**	

COMMENTS TO SUPPORT CLINICAL RECOMMENDATIONS

Participants

Name of Requesting Clinician		**Date**	
Facility Services Coordinator/Contact Person		**Telephone Number**	
Recorded by		**Date**	

cc: BHO/DCS